MIDWIVES TO A "GOOD DEATH": TOWARDS THE DEVELOPMENT OF AN INTERRELIGIOUS EDUCATIONAL PROGRAM TO ASSIST HOSPICE WORKERS IN PROVIDING a "GOOD DEATH" TO PATIENTS IN RELIGIOUSLY DIVERSE CONTEXTS

A Professional Project

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In Partial Fulfillment

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Doctor of Ministry

by Dana L. Cagle

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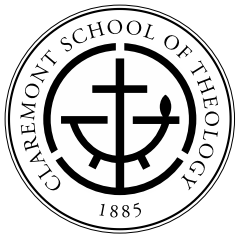
Dedicated to

Jeri L. Peterson



This professional project completed by

DANA L. CAGLE

has been presented to and accepted by the
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partial fulfillment of the requirements of the

DOCTOR OF MINISTRY

Faculty Committee

Rev. Dr. Sheryl Kujawa-Holbrook, Chairperson

Dr. Lincoln E. Galloway

Dean of the Faculty

Rev. Dr. Sheryl Kujawa-Holbrook

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ABSTRACT

Midwives to a "Good Death":
Towards the Development of an Interreligious Educational Program to Assist Hospice Workers in Providing a "Good Death" to Patients in Religious Diverse Contexts

by

Dana L. Cagle

One of the most vital areas of interreligious interaction lies in the work of hospice care. Though this interaction does not fit the model that may often be perceived as interreligious interaction (e.g., table fellowship, intellectual exchange, or sharing of ritual), it is a critical area where the beliefs of the dying person and family need to be assessed by the hospice team in order to facilitate a "good death" for the patient and bereavement assistance for the family left behind. The metaphor of midwifing is used to convey this facilitation in this paper as well as an exploration of the intertwining of hospice work and the offering of hospitality. Though the beliefs of the hospice workers are generally not revealed to the patient and family, those undertaking this work need to be confident to ask the questions, so they can best serve those in their care who may have a different belief system than their own.

This project involved the development and implementation of an interreligious education program for the employees at a hospice company in the Southern California area. Three speakers of three different religious traditions presented issues concerning death and dying from their perspective to employees of the company. These presentations were following by a meal in which participants were encouraged to ask questions and share insights and stories of their own encounters with patient and families who believed differently than they did. A pre- and post-quiz were used to measure if there was an increase in knowledge about the religious traditions

presented. An evaluation was used to determine if the participants felt the program was of benefit to them in their work.

ACKNOWLEDGEMENTS

In the introduction to the 2006 reprint of her 1996 book *It Takes a Village* Hillary Rodham Clinton writes: "This small book with the bright, whimsical jacket provided endless opportunities for headline writers, who have come up with such variations as 'It Takes a Village to Have a Parade!,' 'It Takes a Village to Build a Zero Waste Community,' and, my all-time favorite, 'It Takes a Village to Raise a Pig.'"[1] I now can add another one to the endless list: "It Takes a Village to Complete a Doctor of Ministry Professional Project." In fact, for me it took three villages.

The first village, the Claremont School of Theology community, provided a place of challenge and creativity for this project to be developed, implemented and documented. Thank you to my committee of Drs. Sheryl A. Kujawa-Holbrook and Lincoln E. Galloway and Rev. Stephanie Rice. In her additional role as my advisor I am particularly indebted to Dr. Kujawa-Holbrook for her patience as I passed through a particularly challenging part of my life. My colleague and friend, Kendra Friedrickson-Laouini, provided vital peer supervision and support as well as essential mutual commiserating. Thank you also to Koala Jones for all your tips on navigating the library particularly the most valuable one I didn't listen to at first.

The second village, Reliance Hospice, provided a place to implement this project. Thank you to the management staff for your assistance with this project particularly Astor Lopez for your logistical support and Julia Chacon for your voice of enthusiasm for the project. Thank you to all those who participated in the project particularly the first volunteers on the Valley Team.

[1]Hillary Rodham Clinton, *It Takes a Village*, 10th Anniversary ed. (New York: Simon & Schuster, 2006), xiii.

Thank you, Laura Wilkinson, social worker extraordinaire, for listening when my stress level grew high and being the person who I never had to ask to volunteer because I knew you would!

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CHAPTER ONE

"I only want what is in your mind and in your heart."[2]

-David Tasma

The Beginning

Though hospices have existed since the Middle Ages, their aim was to provide hospitality to travelers, and comfort to the dying and were generally operated by religious orders. Predating these hospices were foundations serving the poor and sick known as xenones in the fourth and fifth centuries.[3] These xenones, however, have a connection to Christianity as well. They were spurred on by the Emperor Julian who concerned by the growth of Christianity caused in part by the Christians care of the sick and poor, called for the priests of the ancient Roman religion to establish these places so the Romans would not be outdone in humanitarian works.[4] One of the most well-known and organized networks of hospices was founded by the Hospitaller Knights of St. John of Jerusalem in the early 14th century to care for the travelers who needed care, rest and safety. It was not until Cicely Saunders (later to be known as Dame Cicely Saunders) began St Christopher's House in London, England in 1967 that the modern hospice movement began. As someone who had credentials as a nurse, almoner (now known as a medical social worker) and a doctor, Saunders was able to bring a unique perspective from all three disciplines into the area of caring for the dying, an area of care that had largely been shunned by doctors with training that

[2]Shirley du Boulay, *Cicely Saunders: The Founder of the Modern Hospice Movement* (London: SPCK Publishing, 2007), 56.

[3]Guenter B. Risse, *Mending Bodies, Saving Souls: A History of Hospitals*, 1st ed. (New York: Oxford University Press, 1999), 81.

[4]Clifton D. Bryant, ed., *Handbook of Death and Dying*, 1st ed. (Thousand Oaks, CA: SAGE Publications, Inc, 2003), 485.

often caused them to view the death of a patient as failure. Saunders' experience at St. Luke's, a traditional hospice at the time run by a community of nuns, prompted her to see the importance of heart in caring for the dying. However, witnessing St Luke's struggle with resources, particularly medical resources and knowledge, and her increased knowledge of the effective use of analgesics in providing comfort for the dying led Saunders to found St. Christopher's Hospice.

Saunders embodied three of the four disciplines Medicare considers required members of the interdisciplinary team in hospices today but did not receive formal training in the core discipline of spiritual care. However, Saunders' own Christian faith was paramount in her work. She believed she had been called by God to do this work based on the experiences in her life. During her adult life she had a conversion experience at a retreat with colleagues and began to identify as an evangelical Anglican. Nevertheless, she was clear that religion would not be pushed upon the patients. Her biographer, Shirley du Boulay attributes the following statement to Saunders: "Considering how little used many patients are to paying attention to religion, it is necessary that they should be approached with tact and gentleness and that they should suffer from no surfeit of food to which they are unaccustomed."[5]

One of the first patients that encouraged her to start her work with the dying was David Tasma, a dying man of the Jewish faith. He declined her offer to read to him at bedside and said, "I only want what is in your mind and your heart."[6] His statement encapsulated for her what dying people may need to hear most from those who are caring for them. Though she examined the possibility of forming the St Christopher's house as a form of religious community with

[5]du Boulay, *Cicely Saunders*, 89.

[6]Cicely Saunders, *Cicely Saunders: Selected Writings 1958-2004* (Oxford: Oxford University Press, 2006), 224.

many of her fellow evangelical Anglicans, she chose not to do so. In her writings she described the hospice in the following terms,

> Above all, we are not concerned with evangelism, with the desire that people should think as we do. We are ourselves a community of the unlike, coming from different faiths and denominations or the absence of any commitment of this kind. What we have in common is concern for each individual . . . and our hope is that each person will think as deeply as he can in his own way.[7]

Though she consulted with religious leaders, as she was not trained as a clergyperson, her own personal faith propelled her in this work and as with many of faith she found strength in scripture. On June 24, 1959 while reading a devotion her biographer details this experience,

> The reading was from Psalm 37. "Commit thy way unto the Lord: trust also in him; and he shall bring it to pass." Suddenly she knew, with complete certainty, that the years of preparation and waiting were over; at last the time had come when she must do something practical towards realizing the dream that had for so long motivated her life. It was as if the verse was intended especially for her. Somehow these words were the tap on the shoulder to say, "Now you've got to get on with it. It was quite irrefutable, I couldn't possibly be disobedient to it."[8]

Her faith and those of faith she depended on carved into the modern hospice movement a permanent niche for spirituality. It forms the third of the three key principles of hospice outlined by Howard Coward and Kelli I. Stajduhar, the editors of *Religious Understandings of a Good Death in Hospice Palliative Care*. These principles are "pain control, a family or community environment and an engagement with the dying person's most deeply rooted spirituality."[9] Saunders' concept of "total pain" includes spiritual pain.[10] The importance of Saunders' emphasis on the role of spirituality in hospice care can be found in the citation for her honorary

[7]Saunders, *Cicely Saunders: Selected Writings 1958-2004*, 227.
[8]du Boulay, *Cicely Saunders*, 85.
[9]Harold Coward and Kelli I. Stajduhar, eds., *Religious Understandings of a Good Death in Hospice Palliative Care* (Albany: State University of New York Press, 2012), 1.
[10]Saunders, *Cicely Saunders*, 263.

degree from Yale University: "You have combined the learning of science and the insight of religion to relieve physical pain and mental anguish and have advanced the humanistic aspects of patient care in all states of illness."[11]

Though there was some openness to different spiritual outlooks from the beginning of the modern hospice movement, it was still very much embedded within a Christian context. When examining funding sources Saunders wrote,

> Of course, we would welcome patients of all denominations or none, and of course welcome anyone who wanted to come and work with us, although they must be able conscientiously and faithfully to take ward prayers. But I do want a Church of England chaplain, and I do want to celebrate Communion regularly in our Chapel, although I would like to welcome other people to take services from time to time, and I do not know really whether I am able, conscientiously, to apply for an undenominational grant.[12]

Inspired by a speech Cicely Saunders gave at Yale in 1963, the then Dean of Nursing at the school, Florence Ward, later served as one of the founders of the first hospice program in the United States, Connecticut Hospice. Ward is often called "the mother of the American hospice movement."[13]

After the founding of Connecticut Hospice, the hospice movement continued to grow in the United States. This growth increased substantially when Congress created a Medicare hospice benefit in 1982.[14] Today this growth has expanded to the point that the National Hospice and Palliative Care organization reported in 2016 there were 4,382 hospices in United

[11]Saunders, 224.

[12]du Boulay, *Cicely Saunders*, 97.

[13]Dennis Hevesi, "Florence S. Wald, American Pioneer in End-of-Life Care, Is Dead at 91," *The New York Times*, November 14, 2008, https://www.nytimes.com/2008/11/14/health/14wald.html.

[14]"History of Hospice Care," National Hospice and Palliative Care Organization, accessed May 7, 2018, https://www.nhpco.org/history-hospice-care.

States.[15] Has the role of spiritual care changed during this rapid growth particularly in the United States? An early document for St. Christopher's Hospice titled "Aim and Basis" defined it as a religious foundation based on the full Christian faith in God.[16] However, Florence Wald reported the following in the published proceedings of a colloquium held at Yale University School of Nursing in 1986 titled *In Quest of the Spiritual Component of Care for the Terminally Ill*,

> By 1980, it became clear to Cicely Saunders and myself that the spiritual side of the care of the terminally ill had not developed in this country. Whether we had approached it differently, whether our culture was different, or whether there was a time lag was not clear.[17]

Though she felt the reasons were not clear she does venture in the same proceeding notes to propose some possible causes for the lag:

> There has been increasing awareness that the spiritual component of care has lagged, however. It may have been partially caused by the enormous amount of time and energy that leaders in the field have had to give to governmental regulations and reimbursement issues . . . There also was a basic flaw in our perception of hospice care from the beginning. Cicely Saunders' blend of medical science and spiritual care wasn't appreciated by many of us . . . Our motivation was a revolt against the disregard of the patient as a person. The American Health care system was still operating under the Cartesian principle that assigned the noncorporeal, spiritual realm to the church and the physical concerns to science. With this division, suffering was difficult to understand and alleviate.[18]

And it is this same country that Wald believes lagged in developing the spiritual side in hospice, that fifteen years later, Diane Eck, Professor of Comparative Religions and Indian

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[15]*NHPCO Facts and Figures: Hospice Care in America.* Revised ed. (Alexandria, VA: National Hospice and Palliative Care Organization, 2018), 6. Accessed March 22,2019, https://www.nhpco.org/sites/default/files/public/Statistics_Research/2017_Facts_Figures.pdf.

[16]Coward and Stajduhar, *Religious Understandings of a Good Death in Hospice Palliative Care*, 15.

[17]Florence Wald, ed., *In Quest of the Spiritual Component of Care for the Terminally Ill: Proceedings of a Colloquium* (New Haven, CT: Yale University School of Nursing, 1986), 21.

[18]Wald, 25.

Studies at Harvard and Director of the Pluralism Project, called the world's most religiously diverse nation.[19] As hospice continues to reach an increased and diverse number of patients and families in the United States education programs aimed to enhance the spiritual care element of hospice must be done within an interreligious context. This requirement is what prompted this project.

The Purpose of this Project

This project sought to explore whether a program can be developed within a hospice that deepens the education of non-chaplain staff on the various elements of religious traditions that will assist them in facilitating a good death for their patients who identify with these traditions, particularly when elements these traditions differ from the hospice worker's background. Many training manuals and textbooks for the members of the hospice interdisciplinary team either offer generalized or at times incorrect explanations of religious traditions. More on the job training is needed to expose hospice workers to the specifics of various religious traditions to assist them in serving their patients with the ultimate goal of a "good death" for the patient.

The Location of this Project

Reliance Hospice has three office locations. The newest office opened in September of 2017 and is in Canoga Park, CA. This office serves the San Fernando Valley and currently has a census of approximately 30 patients primarily in the northern part of the service area. The patient load is growing rapidly, but the staff is still small enough to test out an interreligious education program to see if it would have future merit for the larger staffs at the other two

[19]Diana L. Eck, *A New Religious America: How a Christian Country Has Become the World's Most Religiously Diverse Nation,* 1st ed. (San Francisco: HarperSanFrancisco, 2002), 4.

locations. The staff at this office is not only smaller, but several have worked at another hospice in the past, so the team cohesion is already high. Due to this cohesion an attempt was made to involve all the staff in the educational program to include the administrative worker and the two home health aides who generally do not attend the Interdisciplinary Group (IDG) meeting on Tuesdays.

The Importance of this Project

With hospice becoming a more acceptable alternative to hospital deaths within the general population, particularly throughout the Southern California area, hospice workers of all disciplines need to be mindful of the inherent diversity within this region of the country, specifically as it relates to faith practices and beliefs. Hospice workers need to be cognizant of when and how it is appropriate to touch bodies after death as well as what may be inappropriate to say to patients and families about death either before or after the patient dies. Hospice workers generally are a unique group of caring professionals. A study in the earlier stages of the hospice movement in America came to this conclusion about hospice nurses,

> The hospice nurses in this study, however, defined a decidedly different profile. They were not only markedly more assertive, confident, imaginative, free-thinking and experimental, and independent than the nurses who were working in traditional settings, but also, in many instances, more so even than normal women in the wider population.[20]

A desired outcome of this project was to help such nurses and other team members, both male and female, provide the best care possible and learn how to avoid inadvertently making potentially harmful statements to patients and families. In her

[20]Madalon O'Rawe Amenta and Nancy L. Bohnet, "Traits of Hospice Nurses Compared with Those Who Work in Traditional Settings," *Journal of Clinical Psychology*, no. 40 (March 1984): 418–19.

article “Religion, Bioethics and Nursing Practice” Marsha D. Fowler argues “the study of world religions is critically important to hearing alternative world-views that may define health, moral responsibility, even words and speech in dramatically different ways from our own.”[21] The importance of spiritual care education for healthcare workers is emphasized by Donia Baldacchino in her article “Spiritual Care Education of Healthcare Providers” when she writes,

> Research identifies the active role of the nurses and health care professionals in meeting the spiritual needs of patients in collaboration with the family and the chaplain. However, it is well documented that nurses and health care professionals have overlooked the spiritual dimension in care with the consequence of threatening holistic care.[22]

Participants in the educational program may have learned about their own coworkers’ belief systems in the process of learning about the belief systems presented. If this occurs, it is hoped this will help coworkers learn what statements about faiths and beliefs may bring harm to their own coworkers. I do not believe the hospice workers would intend to harm a coworker in this manner, but this educational program may have illustrated an avenue for people to bring up how they belong to a particular faith/religion/belief and how certain comments can be hurtful to them. No employee, of course, was forced to reveal their faith tradition, but the contributions were welcomed. A hospice worker’s own spirituality likely plays an important part in the care the person provides to the patients. In a study published in 2009, Lisa Astalos Chism and Morris

[21]Marsha D. Fowler, “Religion, Bioethics and Nursing Practice,” *Nursing Ethics* 16, no. 4 (2009): 403.

[22]Donia Baldacchino, “Spiritual Care Education of Health Care Professionals,” *Religions* 6, no. 2 (2015): 605.

A. Magan shared their findings and suggested "that the provision of spiritual care in nursing practice depends, in part, on nurses' clarifying their own spiritual care perspectives."[23]

Nurses generally visit patients at their "homes" (which may be a residence, skilled nursing facility or board and care) one to two times per week. Social Workers visit one to two times a month. Though these disciplines do not necessarily work with a patient's spirituality on an ongoing basis, it is important that they be sensitive to the different aspects of various religious traditions particularly regarding beliefs about death and dying. The educational program was an introduction to these differences in three traditions so that hospice workers can be more aware of what they may be encountering when patients and families are resistant to medication, medical interventions or to discussing other issues which seem to be central to the patient's wellbeing and the healthy functioning of the family unit supporting the patient. It would be helpful for some field workers to realize that the elephant in the middle of the room that patients and families are not addressing may not be due to denial, but a different faith perspective on the dying process.

An anticipated outcome was that participation in this educational program will provide a start to a journey for participants who are willing to venture on such a path rather than just obtain "book sense". During the program, time was allotted for hospice workers to relay stories of cases they had in the past or currently have where religious differences played a part in the care provided to the patient and family. Hospice workers often participate in storytelling among themselves since they generally can't talk about their cases to their families due to healthcare privacy regulations, so this will help provide a venue for that possible stress release as well. For many storytelling is a vital function in hospice work. It may also play a role in the hospice

[23]Lisa Astalos Chism and Morris A. Magnan, "The Relationship of Nursing Students' Spiritual Care Perspectives to Their Expressions of Spiritual Empathy," *Journal of Nursing Education* 48, no. 11 (November 2009): 597.

worker's own spirituality as well. In their article, "Bridging Science and Religion: How Health-Care Workers as Storytellers Construct Meanings", Don Cain, et al., state, "We drew upon and expanded asymbolic interactionist framework to show that careworkers (as storytellers) construct meanings like spirituality as plausible depending on the rhetorical devices they deploy."[24] The researchers also conclude their study shows "how front-line health professionals artfully negotiate the tensions between scientific and religious epistemologies through their spiritual tales."[25]

Though hospice is a growing field there is still a fear among many patients and families that by accepting hospice they are "giving up" versus welcoming an experience that, though difficult, can bring beauty to life even as one is leaving it. The desire of many a hospice worker is to be instrumental in helping their patient have a "good death" and support the patient's loved ones through the process as well. The educational program was aimed at assisting them in facilitating that goal in ways that are within their control.

Who Might Benefit from the Educational Program

The anticipated audience of the program was not only those participating in the program, but the participants at the other two sites of the hospice. This program might be of benefit to hospice workers at other hospices and assist hospice companies interested in developing an interreligious education program to help hospice workers provide a good death to patients of various religious traditions.

How the Educational Program was Implemented

[24]Don Grant, Jeff Sallaz, and Cindy Cain, "Bridging Science and Religion: How Health-Care Workers As Storytellers Construct Spiritual Meanings," *Journal for the Scientific Study of Religion* 55, no. 3 (2016): 482.

[25]Grant, Sallaz, and Cain, 482.

The goals and objectives of the educational program include:

A. Introduce hospice workers to how various faith traditions may view the death and dying process that may be different than their own view.
B. With this introduction the team members will be more sensitive to issues that may arise while providing care to patients and families of various faith traditions.
C. This increased sensitivity will not only assist them in providing excellent patient care but will educate them as to which issues the chaplain needs to be notified about in these cases.
D. For those cases in which the chaplain has been declined the hospice worker will be better equipped to explain to the families how chaplain services include finding a member of their faith tradition during and after the dying process to provide necessary services and counseling and to arrange vital rituals required by that faith tradition.
E. Hospice workers will be exposed to vocabulary and concepts used in traditions other than their own to broach issues that may arise due to differences in religious beliefs.

A consent form was developed and given to each participant explaining the program and their right to participate or not participate in the program. This form as well as all aspects of the program that involve the participants was sent to the Internal Review Board at Claremont School of Theology and approved.

A short quiz was given to each participant that covered three key points from each presentation that the presenter wanted to emphasize. This instrument was given both before and after the program to determine if the key points were learned from the presentations. The participants did not put their names on the quizzes. The average score for both the pre and post project quiz was used to assess if there has been an increase in knowledge. The speakers for

each tradition were approached to help in creating the questions on the quiz. The reason for having anonymous quizzes was to reduce the risk of participants feeling concerned over the score of their quiz. An evaluation of the program was given to the participants after the last presentation to assess if they felt the program benefited them in their work with patients. This evaluation was anonymous.

The three traditions of Roman Catholicism, Judaism and Buddhism were selected as they often have specific rituals near or at death and several patients already on the hospice service either identify as these faiths or cannot always be served by the current chaplain on staff. Due to time constraints only these three traditions were presented. Presentations by members of other faith traditions may be planned for a later time particularly if there are a growing number of patients coming onto the hospice service who are of a faith tradition other than those covered.

Three sessions were planned, and it was estimated each would last approximately one hour and a half in length. The sessions were held on three Tuesdays after the interdisciplinary team meeting a month apart beginning in June of this year. Speakers were encouraged to provide a handout to participants addressing the major tenants of their belief system with an emphasis on beliefs surrounding death and dying.

A hospice staff chaplain who had served as a Catholic priest conducted the session on death and dying from a Roman Catholic perspective. The per diem Jewish Chaplain provided the session on death and dying from a Jewish perspective. A Buddhist monk with experience in death rituals provided a presentation on his faith. Two presentations sessions were recorded for training purposes at the other sites. For these sessions participants were asked to hold their questions until the end of the presentation when the recording device was turned off.

After the sessions participants were encouraged to share experiences of patients they have served who identified with the specific faith tradition being discussed as well as ask questions of the presenter. When the speaker present was not part of the company, participants were reminded to not use names or other identifying facts when discussing specific patients in the presence of the non-company speaker.

Participants were encouraged to be open to individual differences among adherents of any faith and not to approach patients with rigid assumptions, but with flexibility. It was emphasized that these sessions are a brief introduction course only and the intent is to make them familiar with differing religious beliefs on death and dying. The expectation is NOT that they will become experts but perhaps just become more sensitive to what issues may come up in the field due to differences in religious beliefs and preferences.

What Made the Educational Program Less than Ideal

Hospice workers have caseloads and specific requirements on how many times they must visit a patient. New patients must be assessed quickly by all disciplines after admission. Patients are often miles apart from each other. For this reason, time constraints are often pressing when designing meetings and sessions as outlined in this program. The survey presentation style, though not the most desirable for learning this type of information, was chosen due to these time constraints. A modification of a time after the presentation to share specific experiences in the field with patients identifying with the tradition being discussed was added to alleviate this limitation to some degree though it was not expected to eliminate it. This interreligious learning program takes place within the "'marketplace' of human interaction" that Michael Barnes

discusses in his book *Interreligious Learning.*[26] It is within such a marketplace that Barnes argues interreligious education takes place. Arranging for a number of the hospice workers to have the time to listen to a presentation proved to be quite an undertaking in the subset of this marketplace known as the hospice field.

Due to these constraints presentations were limited to one hour with at least one-half hour afterwards over a meal for questions and sharing. The sessions were spread over three months so that participants could absorb some of the material discussed and it would not place an undue burden on hospice workers to meet their frequency requirements for patient visits throughout the month.

How this Paper is Organized

Chapter One: This chapter offers an introduction to this program as well as an outline of the history of the hospice movement specifically how the founder of the modern hospice movement included spirituality as an important part of the dying process. It traced the history to today as hospice's vital role in the lives of many patients and families facing an impending death continues to grow.

Chapter Two: This chapter presents a discussion of the concept of a "good death" found in medical and religious literature. An exploration of factors to consider in order to assist in providing a "good death" for a person within the Roman Catholicism, Judaism and Buddhism traditions will be discussed.

[26]Michael Barnes, *Interreligious Learning: Dialogue, Spirituality and the Christian Imagination*, Reprint ed. (New York: Cambridge University Press, 2014), xii.

Chapter Three: This chapter reviews the textbooks used by some of the participants when training for their respective hospice discipline as well as literature on interreligious learning to outline the strength and weaknesses of the learning model used for this program. It also presents a theological reflection on the intertwining of hospitality and hospice work.

Chapter Four: This chapter provides a description of the implementation of the program to include difficulties encountered and adjustments made.

Chapter Five: This chapter offers any recommendations based on the findings of this project.

CHAPTER TWO

"Hospitality, hospitable, host, hostess, hospital, hostel, hotel, hospice – all these words have the same root. All include the ideas of kindness and generosity to strangers or caring for our fellow beings and offering them nourishment and refreshment."[27]

-Robert W. Buckingham

Definition of a "Good Death"

The root of the world "hospice" is the Latin work *hospes* which means guest, visitor, stranger as well as host.[28] So how does one extend the hospitality of facilitating a good death for someone? And how does one know it is a good death?

During the Medieval Ages a "good" as well as a "bad "death was portrayed in *Ars Morinendi* (translated Art of Dying), in block-book editions that combined words and pictures on the same cut wood block. These depictions were of people on their death bed being faced with many demons and temptations as well as receiving assistance from angels. The dying person's task was to resist the temptations and fight the demons with the help of the angels at bedside. Accomplishing this meant eternal life, the ultimate goal of a good death.[29]

In her book *Preaching Death: The Transformation of Christian Funeral Sermons* Lucy Bregman complains that Christian funerals do not emphasize the traditional beliefs such as eternal life and resurrection and have shifted to more obituary driven services. She attributes a large part of this change to the influence of what she terms the death awareness movement, a

[27]Robert W. Buckingham, *Complete Hospice Guide*, New ed. (New York: HarperCollins, 1983), 11.

[28]"Latin Dictionary and Grammar Resources - Latdict," accessed May 14, 2018, http://www.latin-dictionary.net/search/latin/hospes.

[29]Howard Spiro, Lee Palmer Wandel, and Mary G. McCrea Curnen, eds., *Facing Death: Where Culture, Religion, and Medicine Meet* (New Haven, CT: Yale University Press, 1998), 116–17.

network of individuals and organizations that has brought awareness and discussion of death into the public sector. Bergman attributes this movement with changing the language that many Christians use about death and includes hospice as part of this death awareness movement.[30] In his book *Hospice and Palliative Care*, Stephen Connor writes of the situation before the modern hospice movement began:

> After the Second World War, great advances were made in the science of medicine. Many pharmaceutical agents were developed to treat illness, and techniques and equipment were invented to ward off the dying process. A seemingly unconscious goal was the elimination of death. Dying patients were not acknowledged. People died in institutions, not at home. They did not die, they "expired." They had to be kept alive at all costs; to do less was a failure. The wife of one of my patients responded to a nurse, who wanted to discuss what to do when her husband "expired," by saying "If he is expired, can I get him renewed."[31]

Such was the situation Cicely Saunders faced when she began the modern hospice movement, a movement that returned dying patients to their home or another comfortable environment where they and their dying process were acknowledged. Though Bregman may argue that hospice as part of the larger death awareness movement, may have significantly changed Christian funerals, in the setting of a hospice where this project takes place traditional Christian language and the perspective on dying portrayed in the *Ars Morinendi* of a "good death" would not be appropriate for many patients who identify as Christian and certainly not for the patients hospice serves who identify with faiths other than Christianity. Other descriptions of a good death have been introduced in recent books and articles that would be more appropriate for our purposes. In the 1996 book *Facing Death: Where Culture, Religion and Medicine Meet*,

[30]Lucy Bergman, *Preaching Death: The Transformation of Christian Funeral Sermons* (Waco, TX: Baylor University Press, 2011), 4.

[31]Stephen R. Connor, *Hospice and Palliative Care: The Essential Guide*, 1st ed. (Washington, D.C.: Routledge, 1997), 4.

one of the contributors Frederick J. Streets, a chaplain at Yale University, outlined the following characteristics of a good death,

> (1) One does not die alone; (2) one dies in relative and environmental comfort, (3) one has an opportunity to say good-bye, and (4) dying is enhanced by a "good life" – that is, dying and death are a part of one's entire life.[32]

In a more recent article titled "Defining a Good Death (Successful Dying) Literature Review and a Call for Research and Public Dialogue" by Emily A. Meier et al, the authors conducted a literature search of published qualitative and quantitative studies that provided a definition of a good death from the perspective of patients, families and healthcare providers. In their work, they presented eleven themes they found throughout this review.

1. Having control over the specific dying process
2. Pain-free status
3. Engagement with religion or spirituality
4. Experiencing emotional well-being
5. Having a sense of life completion or legacy
6. Having a choice in treatment preferences
7. Experiencing dignity in the dying process
8. Having family present and saying goodbye
9. Quality of life during the dying process
10. A good relationship with health care providers

[32]Spiro, Wandel, and Curnen, *Facing Death*, 180–81.

11. A miscellaneous "other" category (cultural specifics, having pets nearby, health care costs, etc.).[33]

The National Hospice and Palliative Care Organization writes in their "Preamble to Standards of Practice" that hospice "affirms the concept of palliative care as an intensive program that enhances comfort and promotes the quality of life for individuals and their families."[34] The preamble also states, that "when a cure is no longer possible, hospice recognizes that a peaceful and comfortable death is an essential goal of health care."[35] Thus a simple hospice definition of a good death could be defined as "peaceful and comfortable".

The Role of Pain in a "Good Death"

In these "good death" descriptions comfort (e.g., pain free) appears vital. When addressing pain, Cicely Saunders' used the term "total pain" which includes spiritual pain as well. In an article first published in the *Therapy of Pain* in 1981 she presents this definition of her concept of total pain,

> Pain can blot out the world, cut off all true communication and perpetually renew a vicious circle of pain, fear, tension and further pain. It is no exaggeration to term a patient's suffering as 'total pain' and it may help to divide it into physical, emotional, social and spiritual components in order to assess, understand and treat these people and their feelings better.[36]

Saunders appears to have developed this concept of total pain while doing research work at St. Joseph's Hospice, an early and traditional hospice run by the Irish Sisters of Charity to care for the dying, the frail and elderly and those with long term illnesses. Only three of the nuns

[33]Emily A. Meier, et al., "Defining a Good Death (Successful Dying): Literature Review and a Call for Research and Public Dialogue," *The American Journal of Geriatric Psychiatry* 24, no. 4 (April 2016): 261.

[34]"Preamble and Philosophy," National Hospice and Palliative Care Organization, accessed June 2, 2018, https://www.nhpco.org/ethical-and-position-statements/preamble-and-philosophy.

[35]"Preamble and Philosophy."

[36]Saunders, *Cicely Saunders*, 166.

were trained as nurses and there was no resident doctor. It was at St. Joseph's Hospice that Saunders' began developing the model for St. Christopher's Hospice that started the modern hospice movement. Her emphasis on addressing total pain was clear when after completing a tour of St. Joseph's a group of social work students reported the following observations,

> (1) An absence of pain and drowsiness. (2) Liveliness and peacefulness. (3) An indefinable atmosphere which left one feeling death was nothing to be worried about – a sort of homecoming. (4) Integration – patients, staff and visitors were all of equal importance, there seemed to be no dividing barriers. We noticed especially how easy it was to talk to patients and how easily they accepted us. (5) Simplicity of approach to the problem of pain. (6) Lack of narrowmindedness which might so easily be present in a place run by a particular order, e.g. agnostics, atheists or non-thinkers are helped accept death in the way most suitable for them as individuals, besides those who already have strong Christian faith.[37]

The Role of Spirituality in a "Good Death"

Saunders' Christian faith led her to include spirituality as one of the three elements of hospice care and thus one aspect that needed to be addressed to provide a comfortable/good death for a patient. In the original design of the modern hospice, spirituality played a key role in providing a comfortable and peaceful death for a patient. However, as discussed previously, Florence Ward did not feel spirituality had as much emphasis in the beginning of the movement in the United States. Diane Eck describes the United States as "the world's most religiously diverse nation."[38] If both Ward and Eck are correct, how do we provide this "peaceful and comfortable" death to those from different religious world views in a hospice movement that did not start with an emphasis on spirituality? How do we expand from the original British model so entrenched in Anglican Christianity? What would be helpful for a hospice worker of any discipline to know when caring for those of a belief system different than their own? In

[37]du Boulay, *Cicely Saunders*, 72.
[38]Eck, *A New Religious America*, 4.

examining these questions, let us explore two potentially helpful images to describe the role of a hospice worker in providing a "good death" for a person of another faith.

The Midwife and the Questioning Guide

An image that has often been used in hospice literature to describe the work of the hospice worker is a midwife. As a birthing midwife helps bring a person into the world, another type of midwife can assist in birthing them into a new life or, in other words, helping to facilitate a good death for the individual. Kathy Kalina, a certified hospice nurse, develops this image in her book *Midwife for Souls: Spiritual Care for the Dying*. She draws on her experience accompanying a friend who is a birth midwife on visits to woman giving birth. Both a birth and a death she argues begin with "the shock of diagnosis" even if in the case of the pregnancy it might be welcome news. This experience of shock is followed by consultation with professionals in order to create a "good outcome." The pregnant woman researches for the best actions to take during the pregnancy. The terminally ill person generally seeks for other possible angles to prevent death and then perhaps eventually decides on accepting hospice care. Kalina views the last weeks of both pregnancy and terminal illness as a time of "spiritual searching and life review" as the pregnant mother prepares for her life to change as she brings a new life into the world and the dying person prepares for their life to end and for them to leave this world.[39]

She describes forms of "nesting" that the pregnant mother and the dying person undergo. For the pregnant woman the nesting is a gathering of items to prepare for the birth and for the dying person the nesting is "giving away belongings, putting business in order, and perhaps making funeral arrangements." While the pregnant woman prepares for a loved one, the dying

[39]Kathy Kalina, *Midwife for Souls: Spiritual Care for the Dying*, Revised ed. (Boston: Pauline Books & Media, 2007), 6.

person prepares to let go of loved ones. Both may feel they do not have control over their body. Both have questions about the process they are about to undergo. Both are natural processes. Both can be made more comfortable by medical interventions though some medical intervention may make death uncomfortable and prolong the process.[40] Kalina sums up the similarities in the following paragraph,

> The goal of midwifery in childbirth is a healthy mother, a safe birth for mother and child, and a healthy baby. In midwifery for souls, the goal is a comfortable body, a peaceful passage, and a triumphant soul. The family's active involvement and loving presence gently assist in the achievement of these goals.[41]

The importance of midwifing a "good death" for a patient also assists the patient in undertaking the tasks that Kenneth J. Doka identified in his book *Counseling Individuals with Life Threatening Illness*. The following are the tasks he outlines that are often important to the dying person:

- Dealing with symptoms, discomfort, pain, and incapacitation
- Managing health procedures and institutional procedures
- Managing stress and examining coping
- Dealing effectively with caregivers
- Preparing for death and saying good-bye
- Preserving self-concept
- Preserving relationships with family and friends
- Ventilating feelings and fears
- Finding meaning in life and death[42]

[40]Kalina, 6–7.
[41]Kalina, 7.
[42]Kenneth J. Doka, *Counseling Individuals with Life Threatening Illness*, 2nd ed. (New York: Springer Publishing Company, 2013), 205.

To be a good birthing midwife one must be mindful of the customs and beliefs of the community surrounding the impending death. However, as the midwife in the dying process, one must also consider these customs, beliefs and desires from the perspective of the dying person as a child does not enter the world with customs and beliefs and cannot clearly express desires except through non-language cues. Thus, it is critical for those who "midwife" a death to not only be open to differences, but to have some sense of what the differences may be and how to open a discussion about such differences.

Another image is that of a questioning guide who poses questions in order to be responsive to the spiritual needs of the patient. One biblical narrative that can be foundational for such an approach is the story of the Woman at the Well.[43] This woman honored in the Orthodox tradition as Photina, Equal to the Apostles, showed courage by engaging a man in a theological discussion. In her book *Written That You May Believe: Encountering Jesus in the Fourth Gospel* Sandra M. Schneiders writes that the Samaritan's woman discussion with Jesus is "religious and even theological."[44] Schneiders further writes,

> The woman does not, as is often suggested, introduce extraneous theological issues as a smokescreen to distract Jesus from probing into her shameful sexual life. She begins by questioning Jesus' breaking with Jewish tradition, first by speaking in public to a woman and asking to share utensils with a Samaritan, and second by his implication, in the offering of living water, that he is on par with patriarch Jacob, who gave the well to Israel.[45]

Though a non-chaplain hospice worker may not be called upon to engage in such a theological discussion, it is important to note the honesty of this Samaritan woman in asking

[43]John 4:5-42 (NRSV).

[44]Sandra S. Schneiders, *Written That You May Believe: Encountering Jesus in the Fourth Gospel*, Revised and Expanded ed. (New York: The Crossroad Publishing Company, 2003), 138.

[45]Schneiders, 138.

questions to discover what was truly being said. In the article "Improving Training in Spiritual Care: A Qualitative Study Exploring Patient Perceptions of Professional Educational Requirements," SJ Yardley, et al., write about the patients who were part of the study:

> These patients felt that identifying specific spiritual needs could be facilitated simply by professionals raising the subject, asking questions . . . and engaging in individual discussions over time. Patients did not want spiritual assessment to be a 'tick box' exercise but flexible, allowing them to set the pace and agenda of conversations. This is a challenge to professionals, as the use of national assessment tools may only superficially meet what patients really expect. The importance placed on time and relationships provides patient perspectives on the value of 'knowing the patient', the ability to understand an individual and the ability to select appropriate interventions for them.[46]

These images are by no means the only ones that can be used by a hospice worker to envision and describe the work she or he do with a dying patient of a different faith than their own, but the images can serve as examples of ones that the worker can develop on his or her own to assist them in their work. An image that a worker finds grounding in this sacred work can assist with the spiritual needs of the patient as well as the spiritual needs of the worker.

Caring for Patients across Religious Traditions

As this project is focusing on three religious traditions, we will examine Roman Catholicism, Judaism, and Buddhism in turn. This is not to produce a one size fits all boilerplate for these three traditions, but to provide an outline of some factors that may be important in the care of a patient who identifies with that religious tradition. Though patients may describe themselves as Roman Catholic, Jewish or Buddhist, it does not preclude them from having a different

[46]SJ Yardley, CE Walshe, and A. Parr, "Improving Training in Spiritual Care: A Qualitative Study Exploring Patient Perceptions of Professional Educational Requirements," *Palliative Medicine* 23, no. 7 (2009): 605–6.

perspective on what some may regard as basic tenets of that religious tradition. This discussion is presented as a springboard for questions a hospice worker may ask to avoid making broad assumptions about the care of the patient and to facilitate a good death for a patient.

Caring for a Roman Catholic patient

There are important sacraments in the Roman Catholic tradition that patients may desire prior to death. Though the anointing of the sick is often equated with last rites, that belief is incorrect. Anointing of the sick is not necessarily for those who are near death, even though those with a terminal illness often request it. The Rite of Viaticum is the giving of the last Holy Communion to the dying person. To receive this rite the person must be alert and orientated and able to swallow. Though movies often depict a dying person being in such a state right before death, it often is not the case in the latter days of many lives. If the priest visits while the person is still able to receive the Rite of Viaticum (which is Latin for "with you on the way"), it may prove essential for a devout dying Roman Catholic; but if the person is not able to physically or mentally accept the Communion, anointing of the sick may assist the patient or, if the patient is not alert, the family, in viewing the death as a "peaceful and comfortable" one.

Ethical issues related to their faith may enter into the end of life care for a Roman Catholic. In *Preparing for Eternity: A Catholic Handbook for End of Life Concerns*, Father Joseph M. Champlain writes,

> For many decades, the standard moral distinction was between ordinary and extraordinary means to preserve life. This teaching indicated that we have an obligation and must use ordinary means (food, water, sleep, etc.) to maintain our health. However, while we are not obligated to use extraordinary means (for example, complicated treatment or serious surgery), we may employ them to

> preserve or extend our health and life. In recent years this distinction between ordinary and extraordinary has shifted . . .[47]

One particular area that may require careful discernment for a Roman Catholic patient and his or her family involves nutrition and hydration. The question of whether artificial nutrition (feeding tube) and hydration (intravenously) is ordinary or extraordinary means determines whether the patient and family are obligated to pursue this medical intervention or not. A patient or family may need to consult a trusted priest to determine the best course of action for them to lead to a good death without a sense of ethical conflict. Often patients will be admitted into hospice with a feeding tube and hospice workers need to be sensitive to the role a person's faith may play in the decision of whether to remove the feeding tube or not.

As veneration of the saints is often important for a Roman Catholic, a patient of that tradition may seek solace in images involving saints she or he has found inspiring in their life. The saint in Roman Catholic tradition that one prays to for a "happy death" for either oneself or another is St. Joseph, the earthly father of Jesus. Joseph is often pictured as an older man, much older than Jesus' mother, Mary, and thus dies before both his wife and his son. The fact he is not mentioned in Christian scripture after the scriptures detailing Jesus' birth and childhood is used to support this belief. The image of Joseph as an old man dying in the arms of his son, Jesus, illustrates a visual metaphor for a "happy" or "good" death. This metaphor has its limitations as any metaphor for non-Roman Catholics (for instance bodily contact at death is not always perceived as best for the dying in all belief systems), but the concept of being surrounded by a

[47]Joseph M. Champlin, *Preparing for Eternity: A Catholic Handbook for End-Of-Life Concerns* (Notre Dame, IN: Ave Maria Press, 2007), 15.

loving presence acting respectively toward the dying may have merit for a dying person or family member who identifies as a Roman Catholic.

A former Certified Hospice RN and teacher of Health Care Ethics and Moral Theology, Patricia Kobielus Thompson presents rich imagery from St. John of the Cross that may provide comfort for the dying. She notes that in his works *Ascent of Mount Carmel* and *Dark Night of the Soul*, he describes a process of releasing attachments that might separate one from God. These attachments Thompson argues in her book *From Dark Night to Gentle Surrender: On the Ethics and Spirituality of Hospice Care*, are important to be released in death as well.[48] As one goes through the process of releasing, one finds they are able to accept more of God's love. For those going through this dark night at the end of life, it prepares them for the immense love of God awaiting them in the afterlife.

Caring for a Jewish patient

In the chapter titled "Tradition and Change in Jewish Ideals of a 'Good Death'" found in *Religious Understandings of a Good Death in Hospice Palliative Care*, Norma Ravvin introduces one biblical narrative that is "often raised as a model of a good death and as helpful narrative regarding end-of-life care"[49] in the Jewish tradition. This narrative is the death of Jacob. When discussing Jacob's sitting up in bed despite his weakness to do the final blessing upon his sons Ravvin states this "ideal of intimacy of self-consciousness even willingness to the end, runs through discussions of death in Jewish contexts and bears some similarity to the focus

[48]Patricia Kobielus Thompson, *From Dark Night to Gentle Surrender: On the Ethics and Spirituality of Hospice Care*, 2nd ed. (Scranton, PA: University of Scranton Press, 2010), 178.

[49]Norma Ravvin, "Tradition and Change in Jewish Ideals of a Good Death," in *Religious Understandings of a Good Death in Hospice Palliative Care*, eds. Harold Coward and Kelli I. Stajduhar (Albany: State University of New York Press, 2012), 104.

on mindfulness in the Buddhist and Hindu traditions."[50] A hospice worker caring for a Jewish patient needs to be mindful that the person's place in the family may play a large role in the grief surrounding the impending death.

Prayer is often a communal event rather than an individual one in the Jewish tradition. In the book *Illness and Health in the Jewish Tradition* the editors, David L. Freeman and Judith Z. Abrams write in the introduction to the book that "much of Jewish prayer is conducted in the presence of others and is a part of the spiritual tapestry of a Jewish service."[51] This suggests that the practice of offering extemporaneous prayer at the patient's bedside, as practiced within the Christian tradition, may not be welcomed by a Jewish patient and family.

A Jewish patient and family may also want to seek life-sustaining procedures for as long as possible. In the book *Introduction to Jewish and Catholic Bioethics: A Comparative Approach*, Aaron L. Mackler writes,

> According to the Talmud and later Jewish authorities, the imperative to save life is virtually always decisive, superseding competing considerations: If a building collapses on the Sabbath, the debris must be cleared immediately even though this activity would violate the observance of the holy day, even if it is uncertain whether any person is trapped or whether anyone remains alive. Debris must be cleared even if it is obvious that a victim could live only an hour or two because that short extension of life is precious . . . the Talmud's ruling indicates that brief prolongation of life is valuable; enough to justify violation of the legal requirements of the Sabbath.[52]

As noted in the example above, interpretation of *halakha*, or Jewish law, is important in end of life decisions. Tradition will probably play a central role in the decisions made by the

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[50]Ravvin, 104–5.

[51]Judith Z. Abrams and David Freeman, eds., *Illness and Health in the Jewish Tradition*, 1st ed. (Philadelphia: The Jewish Publication Society, 1999), xxiii.

[52]Aaron L. Mackler, *Introduction to Jewish and Catholic Bioethics: A Comparative Analysis*, 1st ed. (Washington, D.C.: Georgetown University Press, 2003), 89–90.

patient and family. When discussing approaches to maintaining all life-sustaining treatment at end of life, Mackler argues that "Jewish and Catholic positions on these issues represent overlapping spectra, with the Jewish spectrum extending somewhat to the right-expressing greater reluctance to forgo medical interventions."[53]

The hospice worker also needs to be sensitive to the needs of the Jewish patient and family as the death draws very near. In the *Jewish Hospice Manual* Rabbi Maurice Lamm and Dr. Barry M. Kinzbrunner write,

> In Jewish tradition, "bikkur cholim," visiting the sick, is not only a thoughtful act but also a duty. The Talmud says, "Whoever visits the sick reduces their aliment by one-sixtieth," and, "Visiting the sick can hasten their recovery, just as refraining from doing so can hasten their death." So, too, the Jewish tradition requires that a person not be left to die alone. The dying deserve the company of other people. Some families may wish the hospice caregiver to be present in the last moment; other families may ask the caregiver to leave the room. In either case, the caregiver should respect the wishes of the family.[54]

Lamm and Kinzbrunner further state that Jewish law requires someone to stay with the body from death to burial. Burial often must be done quickly after death, particularly if the deceased and family identify as Orthodox Jews.

Family, tradition and the potential desire to have life sustaining measures for as long as possible are three factors that may play an important role in the care of a Jewish patient and family by a hospice worker. Though the perspective may vary on what life sustaining measures are needed based on what form of Judaism the patient and family embrace (e.g., Orthodox, Conservative, Reform, Secular) all three factors are ones that may need to be sensitively

[53]Mackler, 89–90.

[54]Maurice Lamm and M Kinzbrunner, *The Jewish Hospice Manual: A Guide to Compassionate End-of-Life Care for Jewish Patients and Their Families* (North Woodmere, NY: The National Institute for Jewish Hospice, 2006), 51.

explored with the patient and family in order to facilitate a "good death." For a Jewish patient and family with a strong connection to a temple or synagogue the role of the rabbi may prove vital in the care provided. As Rabbi Carla Howard, Executive Director of the Jewish Hospice and Healing Center of Los Angeles (and the presenter on the Jewish faith in the interreligious speaker series of this Doctor of Ministry Project) is quoted in the article "The Compassionate Doula of Death" in the Jewish Journal,

> The Torah commands us to provide for our fellow human beings a good death — and that comes from v'ahavta … love your neighbor as yourself. But a good death? What does that mean? It means treating a death as an entire family experience," she said. "Even though it happens in the body of one person, everyone is affected. The whole family is the unit of care. You have a mini-community that is complicated. Every person brings their own spiritual and psychological piece to it.[55]

Caring for a Buddhist patient

In his work, Phasisan Visalo shares a Theravada Buddhist approach to dying and outlines the following seven aspects of Buddhist spiritual care for the dying: (1) Extending Love and Sympathy (2) Helping Patients Accept Impending Death (3) Helping Patients Focus Their Minds on Goodness (4) Helping Patients Settle Unfinished Business (5) Helping Patients Let Go of Everything (6) Creating a Peaceful Atmosphere and (7) Saying Goodbye.[56] The author also argues that "health care systems should be geared to support a peaceful death, instead of prolonging death at all costs."[57]

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[55]"The Compassionate 'Doula of Death,'" *Jewish Journal*, July 6, 2018, accessed August 26, 2018, http://jewishjournal.com/hospice/235814/compassionate-doula-death/.

[56]Phasisan Visalo, "The Seven Factors of a Peaceful Death: A Theravada Buddhist Approach to Dying," in *Buddhist Care for the Dying and Bereaved*, eds. Jonathan S. Watts and Yoshiharu Tomatsu, 1st ed. (Boston: Wisdom Publications, 2012), 136–47.

[57]Visalo, 147.

An important factor to consider when treating a dying Buddhist patient is allowing the patient to determine the best pain level he or she can tolerate. Self-determination is stressed in hospice; however, hospice staff may not understand that the Buddhist patient may want to tolerate a higher level of pain than other patients so that they can continue their spiritual practices and be as present as possible to each moment. In her chapter titled "Welcoming an Old Friend: Buddhist Perspectives on Good Death" Anne Bruce outlines as "key elements of a good death in a Buddhist context" the following,

> Having a peaceful and clear mind at the moment of death; (2) having pain managed in order to pay attention to the experience of dying; (3) being surrounded by family and spiritual friends; and (4) recognizing the continuity of living, dying, and future rebirth.[58]

The hospice worker also needs to be mindful that a Buddhist patient and family may believe that death occurs many hours after Western medicine has determined the death occurred. There may be rituals that the patient and family desire as death is imminent and after the patient stops breathing. Such rituals may consist of chanting by monks and not touching the body in order to allow the stages leading toward reincarnation or final release from the wheel of reincarnation. It is important the hospice worker ask spiritual leaders or family members present before touching a body even to ascertain if the patient is breathing and the heart is pumping. Often the post mortem care will be provided by other members of the tradition. When a patient who identifies as Buddhist comes onto the hospice service and is living in a facility rather than at a home, a discussion with the facility about when and how the body could be moved to meet their requirements as well as the spiritual needs of the family needs to be held as soon as possible

[58]Ann Bruce, "Welcoming an Old Friend: Buddhist Perspective on a Good Death," in *Religious Understandings of a Good Death in Hospice Palliative Care*, eds. Harold Coward and Kelli I. Stajduhar (Albany: State University of New York Press, 2012), 53.

as facilities often require a body to be removed within four hours of death as determined in the Western medical perspective.

In recent years, Buddhism has brought a wealth of information to the literature on death and dying. In her article "Buddhism, Hospice and the American Way of Dying, Kathleen Garces-Foley writes,

> The main appeal of the Buddhist approach to death appears to be its language of spirituality and its use of meditation practices. While Buddhist concepts like spiritual growth and compassion are not new to Western religious traditions, they are articulated in a language that is appealing to Americans looking for more personally meaningful religious language (Roof 1999) and to professionals needing a nonsectarian language in which to address religious concerns (Walter 1993).[59]

Graces-Foley cites Tony Walter's 1993 article "Death in the New Age"[60] in the journal *Religion* as arguing Protestantism has become increasingly secularized and writes,

> Walter contends that in this situation, when Christian leaders are offering little concrete guidance on dying, Buddhist and New Age approaches are extremely appealing. Buddhist books on dying offer meditation practices for both the patient, whose goal is letting go, and the caregiver, whose goal is cultivating compassion. In either role, these practices allow one to gain a sense of control in a situation of powerlessness. Instead of viewing death as a failure, the position taken in the medical establishment, these practices offer a means to a successful death, a good death, which can be achieved through hard work and discipline.[61]

In her book *Death and Dying, Spirituality and Religions: A Study of the Death Awareness Movement*, Lucy Bregman bemoans the fact she has a "shelf of Buddhist death and dying books" yet a Christian book club brochure she has contains no books on "death, terminal illness, or

[59]Kathleen Garces-Foley, "Buddhism, Hospice, and the American Way of Dying," *Review of Religious Research* 44, no. 4 (June 2003): 350.

[60]Tony Walter, "Death in the New Age," *Religion* 23, no. 2 (April 1, 1993): 127–45.

[61]Garces-Foley, "Buddhism, Hospice, and the American Way of Dying," 351.

bereavement."[62] Bruce argues "the centrality of compassion and the relief of suffering in Buddhism align smoothly with the core principles of palliative care."[63] She believes this "may account, in part, for the growing interest in Buddhism within hospice and palliative care."[64]

Conclusion

Though there is not a standard definition of a "good death" many definitions include the reduction or elimination of pain. Cicley Saunders' definition of "total pain" includes spiritual pain. In order to facilitate a "good death" for their patients, hospice workers must act as midwives of death to be alert to the patient, family and community needs as the patient begins their transition toward the end of life on earth. In this capacity, those that seek to midwife a "good death" for another must be particularly sensitive to how the religious beliefs of the patient and family play an important role in determining if the loved one had a "good death." Though the chaplain often plays the most significant role in addressing the spiritual needs of the dying person and his or her family, it is vital that all members of the hospice team seek the same courage as the Samaritan woman at the well to ask questions to assess what role the beliefs of the patient and family may play in creating their vision of a "good death" for the dying one.

This project and the educational program it developed are intended to be a step in the development of such a team of midwifes gathering at the well with the patient and family in a time of great change (and often crisis) and ask the questions that need to be asked to facilitate the birth of the person under their care into a new life even if the worker may have a different image of what that new life will be from the person and/or the person's family. As hospice care does

[62]Lucy Bregman, *Death and Dying, Spirituality and Religions: A Study of the Death Awareness Movement* (New York: Peter Lang Inc., International Academic Publishers, 2003), 6.

[63]Bruce, "Welcoming an Old Friend: Buddhist Perspective on a Good Death," 53.

[64]Bruce, 53.

not end with the death of the patient but provides bereavement care for a year after the death if the family desires, there may be many meetings at the well to midwife the family into a new life without the deceased person with them in physical form.

CHAPTER THREE

"To live in the middle of things without making premature assumptions about the extent of our understanding of, let alone mastery over, the other is the heart of interreligious learning."[65]

-Michael Barnes, S.J.

Inadequate Resources for Hospice Workers

The literature review began with the perceived need for such a program at hospices when a section of a current nursing book was posted on the social media format Twitter that included the following statements when discussing cultural differences in response to pain,

> Blacks often report higher pain intensity than other cultures. They believe suffering and pain are inevitable. They believe in prayer and laying on of hands to heal pain and believe that relief is proportionate to faith. Jews may be vocal and demanding of assistance.[66]

The textbook was obtained to verify this section had been posted correctly on the social media platform and it was confirmed to be accurate. Though this section of the textbook claims to be based on specific journal articles that it cites, clearly the wording of this section overgeneralizes and may lead to harmful impressions of other cultures and belief systems in the minds of nursing students and, ultimately, nurses. Thus, the literature review for this project began with a review of the textbooks that the various team members used when preparing to serve in their specific discipline to determine if the hospice worker had adequate resources during their training or perhaps may have even been exposed to biased information. One textbook used by a nurse in her prior training did not have such overarching generalities of other

[65]Barnes, *Interreligious Learning*, 26.

[66]Kelly Trakola, Laura Horowitz, and Adelaide McCullough, eds., *Nursing: A Concept-Based Approach to Learning, Vol. I*, 2nd ed. (Boston: Pearson, 2014), 161.

cultures, but addressed spirituality/religion in very general terms as one of the "many culture-related factors" that "affect the patient's health and health care."[67] As she has been in nursing for some time, a later edition may contain more specifics, but as this was the textbook she was exposed to in nursing school this was the textbook reviewed.

Unfortunately, the textbooks used by the other two nurses of the team at the time of the review couldn't be examined as one nurse stated he didn't keep his textbook and the textbook used by the other nurse was never made available. Another recent textbook addressed health related information about religions in a more specific yet culturally sensitive manner. For example, "Jews-Some observe kosher diet to varying degrees (e.g., avoid pork and shellfish, do not mix dairy and meat). Sabbath observation varies (e.g., Orthodox Jews avoid traveling in vehicles, writing, turning on electrical appliances and lights, etc.)"[68]

One certified home health aide provided her textbook *Hartman's Nursing Assistance Care: The Basics* that was published in 2014, but there was no reference to religious preferences of patients.[69] Her school, St. Jude's Nursing School, did provide a handout titled "Religions and Dietary Practices" that was only one page. It did cover some general information on Buddhism, Christianity, Hinduism, Islam, and Judaism but the Buddhist section erroneously stated the Dali Lami is considered to be the highest spiritual leader.[70] The social worker did not recall specifics on religion and spirituality in her textbooks, but only a general section on culturally competent care.

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[67]Priscilla T. LeMone, et al., *Medical-Surgical Nursing: Clinical Reasoning in Patient Care, Vol. 1*, 6th ed. (Pearson, 2014), 22.

[68]Berman, Audrey, Snyder, Shirlee, and Frandsen, Geralyn, *Kozier & Erb's Fundamentals of Nursing*, Global ed. (Edinburg Gate, Harlow and Essex, England: Pearson, 2016), 990.

[69]Jett Fuzy, *Hartman's Nursing Assistant Care: The Basics*, 4th ed. (Albuquerque, NM: Hartman Publishing, Inc., 2014).

[70]*Religions and Dietary Practices* (Panorama City, CA: St. Jude's Nursing School, n.d.)

Increased Awareness of Religious Differences

An anticipated outcome of the educational program was to increase participants' confidence in broaching issues that arise from religious differences by developing a beginning vocabulary in traditions that are not their own. In her book *Understanding Other Religious Words: A Guide for Interreligious Education* Judith Berling calls for "in place of sympathy or empathy, seeing *myself* as the other-and thus still looking through my own cultural and experiential lenses-it is important to attend to the words, images, and behaviors through which the other represents himself."[71]

In the introduction to the book *Learned Ignorance,* James L. Heft defined learned ignorance as "the realization among learned people that their grasp of reality is inescapably limited, prevents all forms of fundamentalism, which assumes the believers are in perfect possession of ultimate reality."[72] This concept provided the rational for explaining to program participants that though they participate they will still not know everything about the various faith traditions they may be exposed to in the field and to remember they are not alone in this experience. The focus was to encourage them to be respectful in discussing differences in the traditions that are discussed and not to lump all traditions under the same umbrella, but to appreciate the differences among traditions and faiths, particularly the ones discussed.

[71]Judith A. Berling, *Understanding Other Religious Worlds: A Guide for Interreligious Education* (Maryknoll, NY: Orbis Books, 2004), 39.

[72]James L. Heft, "An Introduction," in *Learned Ignorance: Intellectual Humility among Jews, Christians and Muslims,* eds. James L. Heft, Reuven Firestone, and Omid Safi, 1st ed. (New York: Oxford University Press, 2011), 4.

Dialogue and Stories

Berling also discusses survey courses as offering "insufficient space and attention to the dialogical or conversational dimensions of learning, both between the learners and the other traditions, and among the learners about the implications of the new knowledge for their understanding of their Christian identities."[73] Due to the limitations of time for this study as it is done in the fast paced and time crunched hospice environment a more interactive element was needed to make up for the limitations of a solely survey course. Current interreligious education literature points to stories and dialogue as being a possible supplement to a survey course. In their work, Eboo Patel, April Kunze and Noah Silverman include storytelling as one of the three sides of the triangle they use to depict the methodology for the Interfaith Youth Core.[74] As discussed in Chapter One, storytelling may play a vital role in constructing meanings in hospice workers' own spirituality about what happens to the patients under their care.[75]

Interreligious Learning

The literature also discusses the need for interreligious learning. In the chapter titled "Understanding Dialogue" found in *Interfaith Dialogue at the Grassroots*, Leonard Swidler discusses a third level of dialogue "prayer or sharing of the spiritual or depth dimension or our traditions."[76] This is the level at which hospice workers will likely engage with their patients as it is the level needed to facilitate a good death for the person. Hospice workers in the field are

[73]Berling, *Understanding Other Religious Worlds*, 84.

[74]Eboo Patel, April Kunze, and Noah Silverman, "Action through Service - From Shared Values to Common Action," in *Interactive Faith: The Essential Interreligious Community-Building Handbook*, eds. Bud Heckman and Rori Picker Neiss (Woodstock, VT: SkyLight Paths, 2008), 123.

[75]Grant, Sallaz, and Cain, "Bridging Science and Religion: How Health-Care Workers As Storytellers Construct Spiritual Meanings," 482.

[76]Leonard Swidler, "Understanding Dialogue," in *Interfaith Dialogue at the Grass Roots*, ed. Rebecca Kratz Mays, 1st ed. (Philadelphia, PA: Ecumenical Press, 2009), 12.

called to work together with chaplains, patients and family members to dialogue at the level of "joint action or collaboration" outlined by Swidler who argues this challenges previously held intellectual beliefs.[77] Sheryl A. Kujawa-Holbrook's "dialogue in action" pattern outlined in *God Beyond Borders* that involves collaborations among people of different religious traditions will be needed to meet the spiritual needs of the patient and family and to provide patient care that respects the religious beliefs of that unit of care (both the patient and the family).[78] Maria Hornung describes "local-level animators" as "hands-on workers" in interreligious dialogue.[79] Hospice workers such a role as they dialogue with their patients and families around two of her four modalities of religious dialogue, specifically, "the dialogue of life" and "the dialogue of making common cause" to provide the best care possible during the end of life process.[80] Non-chaplain hospice workers will need to determine for themselves what level of interreligious engagement is necessary in the care of the patient while still maintaining professional boundaries. However, any informed encounter with a patient/family of a different religious background that occurs as a result of this educational program will be beneficial in enhancing the overall care to that very human unit of care (patient and family) and increases the chance for a "good" death to occur. According to Patel, sociologist of religion, Robert Wuthnow, at the 2003 American Academy of Religion Annual Meeting described religious diversity in United States using the image of an elevator ride:

[77]Swidler, 12.

[78]Sheryl A. Kujawa-Holbrook, *God Beyond Borders: Interreligious Learning Among Faith Communities* (Eugene, OR: Cascade Books, 2014), 38.

[79]Maria Hornung, "Conclusion: Making Dialogue," in *Interfaith Dialogue at the Grass Roots*, ed. Rebecca Kratz Mays, 1st ed. (Philadelphia, PA: Ecumenical Press, 2009), 99.

[80]Hornung, 99.

> Christians, Muslims, Jews and the rest of American's religious diversity are all riding in it together, we are increasingly aware of the other people around us, but we are doing just about everything we can to avoid real interaction.[81]

In hospice work, our goal is to move from avoidance to increased awareness and real interaction.

Though difficult in this environment of defined professional relationships between the hospice workers and those they serve, on some level the information participants receive during this project may open them up to interactions in their life outside work which may resemble more a "Buberian model of dialogue" which is "concerned not with the negotiation of outcomes but with the meeting of persons that is almost an end in itself."[82] By engaging in interreligious interactions that focus on the meeting of persons, I would hope that hospice workers may eventually get to the heart of interreligious learning as defined by Michael Barnes in the quote that opened this chapter.

Theological Reflection on the Intertwining of Hospitality and the Work of Hospice

As discussed in Chapter Two, hospice shares the same Latin root as the word *hospitality*.[83] Can facilitating a good death for a hospice patient also be viewed as a form of hospitality? And can the concept of hospitality be viewed as a means for the hospice caregiver to serve people of different belief systems than their own? The woman at the well (Photina) could be seen as an excellent example of hospitality in an interreligious setting. Metaphorically, the hospice worker could be seen as offering a cool drink from the well of hospitality to the dying person by facilitating a good death that respects that person's humanity.

[81]Eboo Patel and Patrice Brodeur, eds., *Building the Interfaith Youth Movement: Beyond Dialogue to Action* (Lanham, MD: Rowman & Littlefield Publishers, 2006), 19.

[82]Barnes, *Interreligious Learning*, ix.

[83]"Latin Dictionary and Grammar Resources - Latdict."

Hospice work does not entail interreligious dialogue as one might find among religious communities and leaders. The hospice worker does not reveal their religious background unless necessary but seeks to learn any important aspects of the patient and family that may play a part in the dying process. Catherine Cornille points to the "virtue" of hospitality and suggests it is vital in interreligious dialogue.[84] It is also vital for the hospice worker when dialoguing with a patient and family about their beliefs. This virtue of hospitality in hospice delves even deeper into the origins of the word. The Latin root word for both hospice and hospitality, *hospes*, can mean both guest and host.[85] The duality of this root word manifests in hospice work as the hospice worker is coming into another's home yet the worker performs many of the duties of a host by taking care of the person's physical, emotional and spiritual needs. This duality may occur in those who midwife a birth as well as the hospice workers who midwife a death.

Cornille uses the term hospitality to "imply an attitude of openness and receptivity" to differences "as a source of truth."[86] In the case of a hospice worker the "truth" to be sought is the best care for the patient as the hospice worker midwives a "good death" with all that is within the control of the hospice worker, patient and family. This hospitality to another of a different faith/religion/belief may also benefit the hospice worker in examining his or her own belief system though the emphasis in care is always on the patient and family as the unit of care. Though a hospice worker is generally not called upon to share his or her spiritual beliefs (and often to do so would be inappropriate), it is important for she or he to be cognizant of his or her own beliefs in order to be open to the beliefs of the patient and perhaps even initiate dialogue about those beliefs to provide the best care. The internal process this produces within all parties

[84]Catherine Cornille, *The Im-Possibility of Interreligious Dialogue* (New York: The Crossroad Publishing Company, 2008), 4–6.

[85]"Latin Dictionary and Grammar Resources - Latdict."

[86]Cornille, *The Im-Possibility of Interreligious Dialogue*, 177.

to the dialogue may help uncover beliefs not recognized before. Though the internal process in the hospice worker will not overtly play a part in the care of the patient and family, it could play a covert part both positively and negatively. It is vital during this tender time in a person and family's life not to overgeneralize or demonize the belief system as well as the patient and family. She writes:

> The hospitality of our Father Abraham first teaches us a way of relating which does not seek to transform the Other into the Same, which respects their sacredness and separateness. To be hospitable is not to convert, nor to naturalize …For in receiving the Other, in being hospitable to the Other, it is indeed God Himself that Abraham received.[87]

In *Safeguarding the Stranger: An Abrahamic Theology and Ethic of Protective Hospitality*, Jayme R. Reaves outlines three practices of hospitality: table fellowship, intellectual welcome and protection. She defines table fellowship as "the sacramental nature of sharing food and drink."[88] Intellectual welcome is a form of hospitality in which "discussions in scholarship address the importance of creating spaces where a variety of opinions can be expressed."[89] However the practice that Reaves covers in the majority of her book is protective hospitality which she defines as "the provision of welcome and sanctuary to the threatened other, often at great risk to oneself."[90] Reaves argues that by examining protective hospitality and its practice across the Abrahamic traditions a "cooperative theology" could be developed to be "used to address issues of peacebuilding, conflict, marginalization, oppression and threat to the vulnerable in meaningful and effective ways."[91] Though Reaves' definition of protective hospitality does

[87]Abigail Doukhan, "The Hospitality of Abraham: Reflections on a Levinasian Approach to Interfaith Dialogue," in *The Three Sons of Abraham: Interfaith Encounters Between Judaism, Christianity and Islam*, ed. Jacques B. Doukhan (London: I.B. Tauris, 2014), 91.

[88]Jayme R. Reaves, *Safeguarding the Stranger: An Abrahamic Theology and Ethic of Protective Hospitality* (Eugene, OR: Pickwick Publications, 2016), 49.

[89]Reaves, 51.

[90]Reaves, xii.

[91]Reaves, xii.

not entirely fit the hospitality provided to a patient and family by a hospice worker, I believe there is merit in seeing the hospitality that the worker provides as being far more than table hospitality and not a means of intellectual content as sharing of such content would be primarily one way. However, the hospitality provided in hospice does take on a protective role as the hospice worker is facilitating a protective environment in which the patient can die peacefully, that is, have a good death.

One can clearly see elements of the practice of hospitality in all three of the belief systems this project presented to the participants. In the chapter "The Open Tent: Angels and Strangers" in the book *Hosting the Stranger Between Religions,* Edward Kaplan writes,

> To welcome guests we need to have a home. One way to examine the Jewish tradition of hospitality is to view it as part and parcel of the Jewish condition, which has been one of homelessness, instability, and even exile – at least until the recent establishment of the State of Israel in 1948.[92]

Kaplan also cites the "biblical paradigm of hospitality" in the stories of Abraham and Sarah welcoming the three strangers found in the book of Genesis and the origin of the *Seder* found in Exodus.[93] The latter he describes as "an essential part of the Jewish identify as it nurtures a sense of social responsibility, of which hospitality to the stranger is a keynote."[94]

In the book *Hospitality as Holiness,* Luke Bretherton argues that hospice care is "an embodiment of Christian hospitality."[95] He views hospice care as "an embodied and institutionalized form of hospitality" that "recapitulates the ascension/Pentecost moments" in the

[92]Edward Kaplan, "The Open Tent: Angels and Strangers," in *Hosting the Stranger: Between Religions*, eds. Richard Kearney and James Taylor, 1st ed. (New York: Continuum, 2011), 67.

[93]Kaplan, 67.

[94]Kaplan, 69.

[95]Luke Bretherton, *Hospitality as Holiness: Christian Witness Amid Moral Diversity*, 1st ed. (Abingdon, UK: Ashgate, 2006), 183.

Christ event and retains specifically Christian criteria for evaluating good care for the suffering-dying."[96] He discusses the history of the hospice movement that has already been reviewed in Chapter One to point out the influence of Christianity on Cicley Saunders and the early formation of St. Christopher's hospice. It has already been noted in Chapter One the pre-modern hospices were often staffed by members of the Christian faith (specifically Roman Catholic) to offer hospitality to the pilgrims, sick and dying. The Rule of Benedict that governed many of these monks clearly stated: "Let all guests who arrive be received like Christ, for He is going to say, 'I came as a guest, and you received me.'"[97] Though the modern day hospice movement may have started with a Christian view of hospitality, other faith traditions may also contribute to this aspect of hospitality in the hospice movement.

In the Buddhist tradition a refreshing perspective on hospitality is presented in the chapter "The Awakening of Hospitality" by John Makransky in the book *Hosting the Stranger: Between Religions*. He tells the story of a woman going to the Buddha for medicine to revive her dead son. The Buddha sends her back to her village to collect a mustard seed from every home that has not been affected by death. The woman soon learns that everyone has experienced grief and "her anguish was transformed into an intense empathy for all beings in their grief or loss."[98] Using this story as an illustration Makransky asks: "Why should so many others appear as strangers to us, given how much we have in common with them all?"[99]

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[96]Bretherton, 183.

[97]Amy G. Oden, ed., *And You Welcomed Me: A Sourcebook on Hospitality in Early Christianity* (Nashville: Abingdon Press, 2001), 77.

[98]John Makransky, "The Awakening of Hospitality," in *Hosting the Stranger: Between Religions*, eds. Richard Kearney and James Taylor, 1st ed. (New York: Continuum, 2011), 110.

[99]Makransky, 111.

Though today the hospice worker provides care to dying patients and their family one day the role may be reversed (if the hospice worker dies on hospice) and this former caregiver will be receiving care from someone they may or may not regard as a stranger. Recognizing the reality of death for us all rather an abstract concept may take the stranger element out of hospitality in the hospice setting. If we are not strangers to the grief that death brings, and we will one day be intimately acquainted with death when our own comes to call, shouldn't the hospitality that we provide to each other during times of grief and death actually be seen as providing hospitality to our very self? A Buddhist might even argue that even this very "self" is an illusion.

Hospitality weaves throughout hospice work bringing together lives brought together by death. This weaving may not look as one would imagine interreligious dialogue and does not fit the traditional depictions of sharing a table or engaging in intellectual discussions about differences of belief. It is an intimate and emphatic delving into the beliefs that has held one's life together and how those beliefs fare when facing the cessation of life as one knows it. Hospice is truly a hospitable act in the interreligious tapestry of life when encountering death, whether the death of another or your own. All three traditions explored in this project can provide a helpful lens into the concept of hospitality in the work of hospice for all have attempted to respond to the many questions that arise with impending death.

Conclusion

A literature review of the textbooks that could be obtained previously used by current hospice workers on the Reliance Valley team in the initial training for their respective disciplines pointed to a need for more specifics about particular belief systems to assist hospice workers in serving patients of different religious traditions. The review of the literature also indicated

lecture alone would not be the best option for the educational program, but, unfortunately, due to time constraints this type of the presentation style would be best option. A meal was added after each presentation to provide a more interactive element to the program for questions and discussion as the literature indicates that interactive learning can be more effective in interreligious education.

As this was an interreligious education project, a theological reflection of hospitality was undertaken as this theme often appears in literature about interreligious dialogue. Though the model of dialogue in the hospice setting is not the same as the experience among those in religious communities, this reflection argues hospice embodies the original Latin world of origin as the hospice worker serves as both host and guest. The theme of hospitality in each of the three belief systems that were presented in this project were also discussed.

CHAPTER FOUR

"The best-laid schemes o' mice an' men
Gang aft a-gley,
An' lea'e us nought but grief and pain,
For promis'd joy."[100]

- *Robert Burns*

Implementation of the Project

The sessions for the interreligious speaker series were held on three Tuesdays spaced approximately one month apart. The sessions were planned on the day of the Interdisciplinary Group (IDG) meeting when several members of the team would be present. On June 26th a chaplain employed by the company who was a former priest spoke on the Roman Catholic faith. On July 31st the per diem rabbi spoke on the Jewish faith and on August 28th, a Buddhist monk gave a presentation on Buddhist beliefs.

The participants in this project were employees of Reliance Hospice and included all hospice disciplines. These disciplines included administrators, registered nurses, vocational nurses, social workers, certified home health aides, and chaplains. Prior to the start of the speaker series, volunteers for the research portion of the project were recruited through emails and announcements during the Interdisciplinary Group (IDG) meetings held prior to the start of the project. The process was explained to those who had expressed an interest in participating in the research portion of the project in person or by phone. It was possible to meet with several individuals present at the IDG meetings and consent forms were signed at that time if the person was interested in participating. Those who did not attend the meetings were contacted by phone

[100]Gordon Wright, ed., *Poems and Songs: Robert Burns* (Edinburg: Gordon Wright Publishing, 1981), 35.

or in the field and either completed the consent form in the field or came into the office to sign the form. As the management of the company wanted to open the presentations to the other offices, the process was explained by phone at a meeting held in the main office. Copies of all consent forms were made and given to the individuals.

A quiz was developed with the speakers of each presentation to be used as a pre-quiz and post-quiz (see Appendix A). Each presenter was asked to either develop the questions or provide three points they felt were important for the participants to know about their faith/tradition. The Roman Catholic presenter developed his own questions including the multiple choices in the questions. The Rabbi and the Buddhist monk were given suggested questions for their presentation based on information provided on the main points of their presentations. These questions along with the false choices and the correct answer were given to each of these presenters to review and approve before being including in the quiz. Each quiz consisted of nine questions: three for each presentation.

A pre-quiz was given to participants to complete and turn in before the first presentation on June 26th. A folder labeled "Pre-Quiz" was placed in the office so participants could turn in the item anonymously. Pre-quizzes at the other offices were collected with the help of a chaplain assigned to the main office. The pre-quiz clearly stated not to put a name on the paper. Thirteen consent forms and pre-quizzes were turned in prior to the first presentation.

The goal was for hospice workers to gain some basic knowledge about a religious tradition to assist them in determining what questions they may need to ask of a patient and family that identifies as belonging to one of the three religious traditions presented in the program. With this basic knowledge the expectation was the hospice worker's confidence in knowing appropriate questions to ask patients and families would increase. This would assist

them in midwifing a good death for the patients under their care as well as the families experiencing the death from the perspective of a loved one.

After each presentation by the speaker a lunch meal was provided by the hospice company for the speaker as well as the participants at the Valley office where the presentation was held. Employees of the company at the other offices were invited to call in to hear the presentation as well though not all announced themselves when calling in or called in late when it would have been inappropriate to announce themselves as the presentation was already in session. Employees were not necessarily physically located at one of the other offices but could have been calling in from the field on their own company cellphone.

Participants were invited to ask questions during the lunch time and also share stories of patients (without mentioning names) they had served who held the particular belief system discussed that day. No one shared such stories after the three presentations though some questions were raised. One participant shared how he felt he could not be open about being in a particular organization at a church he attends after the presentation on the Roman Catholic faith. As the lunch was served in another room and there was limited seating at times, often people would break up into smaller groups instead of staying together as one large group. As one of the newest offices, the Valley office space only consists of the conference area, a work station area (where the lunch was put out) and a supply room so space is more limited than at the main office in Torrance. Thus, the anticipated discussion over the meal did not fully occur. In addition, for the presentation by the Jewish rabbi, the conference room had to be vacated at the last minute for another group and everyone met in the workstation area which was not as spacious as the conference room area. Even in this case, when the meal was served, participants broke into small groups to talk socially or about work-related matters.

At the end of all three presentations a post quiz was given to research participants to complete. The same questions were asked as on the pre-quiz in order to see if the important points the speakers wanted to relay to the participants were learned. In addition, an evaluation was handed out to those who participated in any of the presentations and who wanted to give feedback on the portion or portions of the series in which they participated. Both the quiz and the evaluation were anonymous. Manila folders labeled "Post Quiz" and "Evaluation" were placed in the Valley office for participants to return these forms anonymously. For those participants in the other offices the chaplain who had assisted in the collection of the pre-quiz and consent forms had an envelope addressed in which participants from other offices could place their post quiz and evaluations. This envelope was mailed after the all the forms were collected. A week was given for participants to turn in their forms. This allowed for the participants who attended the IDG meetings to have two opportunities to turn in the form when they typically came into the office.

Results of Pre- and Post Quizzes

At the end of the series eleven quizzes were turned in. Thirteen pre-quizzes had been turned in. One participant who had signed a consent form left the company prior to the end of the speaker series. Each quiz originally consisted of nine questions: three for each presentation. On the thirteen pre-quizzes turned in there were a total of 50 questions missed. Each quiz consisted of nine questions; three for each presentation. When the number of missed questions was divided by the number of quizzes (13), the average number of incorrect answers was 3.9. The hoped-for outcome was that this interreligious education project would lower the average number of incorrect answers to show that knowledge about the three traditions had increased.

Though prior emails with the Buddhist monk had generated a set of three questions and the answer for each was confirmed with the him prior to creating the quiz at the beginning of the series, comments the presenter made during the presentation caused the correct answer to be unclear so the last question on the quiz was discounted. The tabulations for pre-quizzes were then recalculated with the same question discounted. The total number of incorrect answers on the pre-quizzes was adjusted to forty-two (42) incorrect answers and an average of 3.2 incorrect answers per quiz. Before this adjustment on the post quizzes the number of incorrect answers was thirty-four (34) and the average number of incorrect answers per quiz was 3.09. With the adjustment of eliminating this question for the post-quiz the number of wrong answers decreased to 24 and the average wrong answers per quiz reduced to 2.2. Thus, with the adjustment the average number of incorrect answers decreased by one question.

Feedback from the Evaluations

Twelve evaluations were also collected. Everyone was invited to fill out an evaluation if they attended at least one of the presentations. For questions 1 – 4, participants were asked to respond if they strongly agree, agree, disagree or strongly disagree with the statement. There was also a no opinion option listed in the middle of the continuum. A copy of the evaluation can be found in the Appendix B. No one marked disagree or strongly disagree to any of the four questions on any of the twelve evaluations. Six people strongly agreed, and five people agreed that the series will help them in serving patient they have or may have who identify as Roman Catholic. One participant had no opinion. The same breakdown of responses was recorded for the question regarding Jewish patients. ("The series will help me in serving my patients that I have or may have who identify as Jewish.") The results for the statement that the series will help the person in serving patients who are Buddhist received stronger agreement scores with eight

respondents marking strongly agree, three agree and one no opinion. There was also a favorable response to learning more about other faiths. The fourth statement read: "I would like to hear more presentations from speakers of other faiths." For this statement five people marked strongly agree, six marked agree and one marked no opinion.

In hindsight the "no opinion" option may have been unclear on the evaluation. Participants were instructed to check the "no opinion" option if they had not attended a specific presentation. A place to check "did not attend this presentation" would have been clearer for the participants.

Participants were also asked on the evaluation to list other religious traditions that they would like to hear more about if they were interested in hearing more speakers. Five participants answered this section of the evaluation with some participants listing more than one answer. "Muslim" was listed four times. "Other Christian denominations," "Protestant," and "Jehovah Witness" were each listed once.

When asked on the evaluation what the participant liked best about the speaker series, the responses included,

> "Just the different perspectives and yet the similarities of different faiths. Much needed by me. And I loved that they related all to cover the medical care we provide."
>
> "Buddhism"
>
> "Variety of topics, the knowledge of the speakers, incorporating the info into hospice relevant topics kept it interesting"
>
> "The different types of presentations"
>
> "I was able to hear firsthand of specific traditions from subject matter experts "
>
> "The priest was good, and I enjoyed the Rabbi. She was very knowledgeable."
>
> "Learning about religions and other cultures"

"Thorough explanation to various series."

"As a nurse, it helped with what is needed to be done during death visits for different religious backgrounds."

Three evaluations did not have any responses to this question.

When asked what the participant liked least about the speaker series, the comments ranged from language barriers to the need for more time. However, no one seemed to have theological or religious objections to hearing about other traditions.

When participants were asked if they had suggestions for improving the speaker series the following comments were given,

"Interpreter possibly. I also thought the PP [PowerPoint] by Buddhist monk was great. Others should use similar format."

"Include other religions. I'd be curious about other Christian denominations."

"Add others from lesser known faiths."

"Provide more time for them and follow up."

Four participants left this section blank. Two put N/A. And two had just specific comments such as "You did great" and "None, Dana did a fantastic job."

Best Laid Plans…

Before the project began the Administrator of the Hospice company made the presentations mandatory for the social workers in the company. He also wanted employees from the other offices to be able to call into the presentations. The project had been developed with the Valley office serving as a test site before the project was refined for the other offices. The approval of the Claremont School of Theology Internal Review Board also was contingent on participation in the project being voluntary. Information was sent out via email and on the phone

during a social worker/chaplain meeting clarifying that though the presentations may be mandatory for some, participation in the research portion of the project was strictly voluntary for everyone. Having people call in to the presentations did increase the number of research participants as some from the other offices did volunteer to participate in the research portion, but it was difficult to determine the actual number of people listening to the presentations the logistics involved in collecting the research materials in an anonymous manner had to be developed as previously discussed.

The limitations of time and the seemingly perpetual chaos of hospice work did detract from the project. With the constant pressure to visit patients in compliance with Medicare regulations especially new patients there was a sense at times that a more leisurely approach to the presentations would have been beneficial, but the fact that the project received so many positive comments despite the time constraints was encouraging. Based on the evaluations there was a sense that more time was needed.

The qualitative remarks on the evaluations indicated that there was a perception among several of those who participated in the series that it would benefit them in their work in the field with people of faith backgrounds different from their own. This was the ultimate goal of this project. The project may also have assisted the employees with understanding their own faith as many participants crossed themselves with the sign of the cross after the presenter on the Roman Catholic faith presented a prayer.

Though the lunches provided might not have generated as much discussion as desired, they did provide a time of questions and a time of connection as one on one discussions were often observed between the presenters and individual employees. In addition, there was one immediate positive result of the one presentation that was reported shortly after the one

presentation. A nurse admitting a Buddhist patient stated she knew what questions to ask the family particularly about not touching the body for eight hours. This was important information to collect as soon as possible as the patient was in a facility with a policy (that many skilled nursing facilities have) that when a resident dies the body must be removed within four hours. Though the patient identified as Buddhist, the family relayed (as the patient was not responsive) that the patient had not actively practiced this faith for some time and the touching the body upon death would not be an issue. The nurse was thus able to know what questions to ask and did not assume that as a Buddhist the eight hours would be required. The desired effect of this program that the hospice workers would have some background of a particular faith in order to know what questions would be important to ask seemed to have occurred in this particular incident. If this almost immediate effect could be produced, the likelihood of long-term positive results could also occur as these hospice workers take what they learned out into the field in their interactions with patients and families and build on this knowledge.

Conclusion

Though there were logistical issues that arose such as changes in rooms used, addition of participants at other locations that were physically distant from the primary location of the presentations, and the persistent challenge of time and stress in hospice work, this project seems to have had a positive effect in assisting hospice workers in their role as midwives to the dying process for their patients and families. Quantitatively, there was a slight increase in the number of correct answers on the post quiz taken after the last presentation when compared with the pre-quizzes given before the presentations. The increase was not as high as had been hoped, but the evaluations seemed to indicate that participants overall felt that participating in the project would assist them in caring for their patients who identified with the three different religious traditions

presented. The evaluations also indicated a desire for future presentations, a perceived value in hearing about different religious traditions and the positive impact it would have on their work with the dying. The evaluation was also helpful in collecting participants' input on additional presentations that the hospice workers felt would help them with patients of other religious traditions not covered by this educational program.

Despite the challenges presented during the process of implementing this program positive results were produced. The immediate effect after the Buddhist presentation is hopefully a harbinger of more positive outcome to come in the work of those in the company who deal directly with the care of the patients and families. Several weeks after the presentations, a participant expressed gratitude for the project even though she was initially hesitant to participate due to the time it would take out of her busy schedule. This project suggest that even in the busy "'marketplace' of human interaction" found in hospice some connection can be established between the hospice worker and the patient and family so that the hospice worker can midwife the dying person to a peaceful death within the context of hospitality – both hospitality to the dying person and the dying person's hospitality to the worker as both learn from each other as in any transforming interreligious interaction.[101]

[101]Barnes, *Interreligious Learning*, xii.

CHAPTER FIVE

"Prediction is very hard, especially when it's about the future."[102]

- *Yogi Berra*

Why Future Interreligious Education Programs are Important

Often the spiritual aspects involved in an impending death take a backseat to the physical aspects. Incorporating education programs as the one undertaken in this project bring those spiritual aspects to the forefront. Spiritual aspects of dying often deal with the dying person's expectations of what may be on the "other side" of this life (if anything). If a dying person identifies with a particular religious tradition, s/he may hold specific expectations not only about how the dying process should occur, but also how s/he will experience life after death. As midwives engaging with the dying and their loved ones these expectations need to be addressed as well as the physical aspects of dying. Hospice workers who feel more confident about engaging these spiritual aspects (as the answers on the evaluation seem to indicate) will be more likely to engage their patients and families in discussions as the one Photina courageously entered into with Jesus at the well.

Often a chaplain addresses the spiritual aspects involved when an impending death face a patient and family. Programs such as these are not designed to replace the experience and expertise that a chaplain can bring to the care of a patient and family. A program such as this one is intended to provide non-chaplain staff who have continuous and ongoing encounters with

[102]Leslie Alan Horvitz, *The Quotable Scientist Words of Wisdom from Charles Darwin, Albert Einstein, Richard Feynman, Galileo, Marie Curie, Rene Descartes, and More*, 1st ed. (New York: McGraw-Hill, 2000), 162.

the patient the confidence to interact with the patient in ways that are mindful of the patient's spiritual and physical care.

Educational programs as the one implemented in this project are also vital in hospice as they may have a possible effect on the continued formation of the hospice workers' own spirituality. Though it was not feasible to measure the long-term effect this program had on the participants in this project, future programs could implement such a measurement to evaluate the effect such programs have on the enhancement of the hospice workers spirituality. This examination of their own spirituality could play a large role in the care that the hospice worker gives to not only his or her present patients, but also future patients that may come under his or her care. As the hospice worker is exposed to religious traditions that may differ from their own the hoped-for result would not only be a worker with a more sensitive and caring approach to these differences, but also a refining of the hospice worker's own spirituality and thus a benefit to the worker as well as all those he or she comes in contact with both in and outside of the work environment. This ultimately could result in a positive effect on not only the hospice worker's personal life, but also the part of the world in which the hospice worker resides. Knowledge of other religious traditions could lead to the hospice worker educating those he or she encounters throughout his or hers sphere of influence and not just in the work environment. This may lead to possible ripples throughout and beyond those that the hospice worker encounters and educates directly as the knowledge is passed on from person to person. Witnessing such positive care from someone of another religious tradition may assist the survivors with their bereavement after the death and also provide a positive perspective on hospice that still is viewed as "giving up" by many families. The benefits of interreligious education programs in hospice clearly could have a long-term benefit for both hospice and the world.

Specific Recommendations for Future Interreligious Education Programs

The biggest obstacle in the implementation of this interreligious education program in a hospice setting was time. Hospice is often a fast paced and stressful environment particularly for the case managers who must make sure Medicare requirements are met while caring for a person and family members dealing with the stark reality of an impending death. The case managers are supported by social workers and chaplains when the patient and family are open to these services, but the brunt of the work often falls on the shoulders of the registered nurses. It can also be a stressful and fast paced environment for all the disciplines particularly if there are dysfunctional family dynamics that may be exacerbated with the impending death or when several new patients come onto the hospice service at the same time. The hospice does not have control over how many referrals it may receive and from what referral sources so at times numerous new patients come on to the service at the same time and the assessments for all the disciplines need to be completed within Medicare guidelines. At times a family may request a discipline to delay the initial visit as the patient and/or family may be overwhelmed by all the disciplines trying to make their initial visits. In these cases, a note is placed in the chart.

In this often fast paced and stressful environment it is challenging to coordinate the schedules of participants for an interreligious education program in one place let alone in one place in a calm environment. To benefit from the dynamics of face-to-face encounters not only with people of different faiths and their own coworkers, it is best if participants are physically in the same room. This, however, is difficult. Though the Interdisciplinary Group (IDG) meeting often draws registered nurses, social workers, chaplains and some administrative staff into a physical space together there are still times a hospice worker may have to call into a meeting (e.g., a registered nurse traveling to admit a new patient). Other disciplines are often not at the

meeting such as Licensed Vocational Nurses (LVNs) and Certified Nursing Assistants (CNAs). The latter often have a very close and intimate relationship with the patient as they aid with personal grooming and are often visit the patient more than any other discipline. The CNA that deals with the patient's body in an intimate way may encounter the most interreligious territory to navigate in their care of the patient and encounters with the family. Unfortunately, their schedule is the most difficult of the disciplines to work around to schedule training at the same time as the other disciplines as CNAs are often requested in the morning and end their day in the afternoon. One recommendation for anyone attempting to do a similar project at a hospice would be to examine the possibility of conducting a separate program for the CNAs tailored specifically to potential issues regarding a patient's body when encountering different belief systems. This training could be held for both CNAs and LVNs as at times LVNs are asked to give personal grooming care if a CNA is not available.

Even if several of the disciplines are together for a face to face interreligious education project it is often hard to have a milieu that is conducive to some of the thoughtful encounters needed for interreligious work. Often staff are besieged with emails and text messages coming to them from patients and patient families who contact the office requesting call backs or visits particularly from the nurses. Office staff may also be contacting the field workers about calls into the office or administrative requests from management. It can be difficult at times for hospice workers to find time to do the charting required on their laptops after completing visits. An oft-repeated oral admonishment in the medical field is "If it isn't charted, it didn't happen." Due to all these demands staff sitting in an interreligious education program may be tempted to look at their laptops during the program in order to catch up on the charting or answer the steady stream of emails that generate perpetual work for all disciplines. Fortunately, no hospice worker

was seen working on their laptops during any of the presentations in this educational program though some did check their cellphones and on occasion go outside to make a call.

The task of creating such a calmer environment for learning of any kind is a challenge for the hospice field. It is often difficult at the beginning of the IDG meeting to facilitate a time of silence with people calling in or walking into the meeting late. At times there may be a side discussion on a matter with another person in the meeting at the home office that is calling into the meeting who are unaware a time of silence is occurring. Any interreligious project that is undertaken in a hospice will require management support and perhaps creativity in developing this environment that would be more conducive to learning and to absorbing more fully not only the perspectives of different religious traditions, but also the perspectives of each other. Perhaps a place could be found to have the training other than the room where IDG meetings are usually held. Being away from a "work" room might help the participants minds refocus on what is needed during this type of education as well as inner spiritual formation that may occur as well.

Music could also be used to a creative degree to set the tone upon entering this "new" non-work-related room. Soothing music could be playing as participants enter. Signs could be placed asking people to enter the room quietly. Management could also explore the possibility of asking participants to leave their cellphones (both work and personal) outside this room so it can become a sacred place of quiet reflection and exploration. This would be quite a change from the typical workplace pace and environment of hospice and may alert the participants that something different is going to happen here that will require a new mindset and a new approach than what is usually used or required in the workplace.

If possible, all participants should be in the room physically. As this is often a challenge with different offices in distant offices (by Los Angeles traffic patterns, not just miles), creative

uses of technology could bring the participants who are not able to be in the room physically into the room in a visible as well as audial way.

If attention is paid to the actual environment in which the program is conducted the added element of interaction not only with the presenter, but also with other coworkers may be enhanced but and may prove to be the most valuable part of the program. A hospice that serves a large number of patients with a great diversity of religious traditions might find it beneficial to create a more conducive learning environment by blocking off more than two hours. If this was viewed as a great benefit to the company an entire day of immersion into not just one but several faith traditions might prove valuable. Often several areas of education are competing for time set aside for training and so dedicating a great deal of time to introducing different religious traditions to hospice workers would need to be seen by the management as a high priority.

One comment on the evaluation recommended that there not be as much time between presentations. The presentations were spaced out over three months in order to allow participants time to absorb the information presented. The presentations format was chosen rather than the panel discussion method with several religious traditions presenting so that each presenter would not have to compete with the others to get "time" in to explain the important topics concerning death and dying to the participants. Since this time to deal with each religion is preferred, it will be necessary to convince management of the need for time and space to deal with the spiritual dimensions of care from an interreligious perspective.

In hindsight, a greater emphasis should have been placed on the handouts that were given to the participants. The speakers had different approaches to their presentations. Each was asked to provide a one-page handout if possible. The presenter on the Roman Catholic faith provided a two-page handout. The rabbi provided a small handout with poems from an

eighteenth-century Jewish mystic on effective words and effective silence that she read at the end of the presentation. The Buddhist monk had a very visually pleasing PowerPoint presentation that was sent to all the participants. One comment on the evaluations suggested all presenters be asked to provide PowerPoint presentations in the future. Ensuring participants have something to take with them was an area that was not emphasized as much as could be for future presentations. Visual learners might find this particularly helpful. It might also have improved the scores on the post quizzes.

What continues to be vitally important in the implementation of future educational programs of this type in the hospice setting is the commitment of management to not only allow the implementation of these programs, but also to prioritize them in the training schedule. Anyone implementing an interreligious educational program in a hospice first needs to ensure the management who will be coordinating the logistics and approving the expenses of such a program are not only supportive, but also willing to prioritize such a program within the training schedule of a hospice; a schedule that is often filled with requirements mandated by other agencies that the hospice must ensure are completed. The management at Reliance Hospice was supportive in this endeavor though the suggestions for future educational programs noted in this section such as setting aside a non-work-related room and perhaps even setting aside an entire day to listen to several religious traditions might have been more difficult to implement and thus would have required more planning and more coordination with management. As the Reliance Hospice is currently in three offices that are a significant distance apart the suggestions in this section might prove difficult for a companywide program but might be feasible at each one of the offices. This would require a contact person at each office to coordinate such a program

Conclusion

As with any interreligious education program undertaken in the hospice environment there will be tradeoffs and compromises due to the fast paced and stressful environment of hospice work. The program implemented for this project had its limitations, but still appeared to have made a difference not only in the perceived benefit of participating in the program assessed through the evaluations of the participants, but in a slight quantitative increase in the participants' knowledge about the three religious traditions presented though the sample used was small.

The program can be enhanced in an environment that fosters more interaction between the participants and the presenter as well as among the participants themselves. This might include the opportunity to role-play, demonstrations, and visual materials for participants to engage that would lead to greater attentiveness to the subject matter.

This project did have its merits and similar programs could prove to be beneficial for those doing hospice work and having to dialogue across what may be perceived as a divide of beliefs. Hospice is truly a field where this divide needs to be crossed in any way possible in order to provide a good death. One of the most critical times that a person's religious tradition can come into play for good or for ill is as that person nears the time of death.

This project focused on the need for hospice workers to focus on the needs of the patient and what the patient needs for a good death. The training offered by this project has the potential to challenge hospice workers not to impose their beliefs of patients and their families in this very difficult and vulnerable time. It is a time that brings into view certain religious questions that relate to what happens after one dies. The hospice worker, as an adherent of a particular religion,

cannot claim their beliefs as the one true belief. Eckerd Tolle wrote in his book *Stillness Speaks*: "Death is not the opposite of life. Life has no opposite. The opposite of death is birth. Life is eternal."[103] If we accept this view, then the hospice worker is helping the patient from life into life and facilitating life after death.

More educational programs need to be developed in other hospices for non-chaplain staff so that all can meet the patient and family members where they are, not where the hospice workers think they should be. Just as all members of the hospice team are called upon to ask patients about their level of pain all members of the team also need to be aware of areas within their scope of practice that might be influenced by a person's religious traditions such as how to touch a body before and after death and the need for a body not to be removed within a certain time period. The hospice worker is there during one of the most vulnerable moments for a person and those that love that person; the period when their time together on this earth is coming to a close. The work of hospice has a sacred nature to it. This sacredness requires that educational programs as the one implemented in this project be incorporated into the training of all staff even if the limitations of time and space may make the learning less than ideal. Any education to prepare the hospice worker to midwife the person and their loved ones in preparing for the moment of the last exhale is sacred in and of itself and must be attempted despite the clamor of space and time limitations.

[103]Eckhart Tolle, *Stillness Speaks* (Novato, CA: New World Library, 2003), 103.

APPENDIX A

Pre- and Post-Quiz

Please do not put your name on this quiz. This quiz has questions on the back as well.

1. Which of these beliefs is not an official teaching of the Catholic Church?
    a. Purgatory
    b. Veneration of the Saints
    c. Limbo
2. Anointing of the Sick is for all these things EXCEPT for one:
    a. For the forgiveness of sins
    b. For physical healing
    c. As a substitute for baptism
3. True or False: The Catholic belief in Purgatory praying for the dead can be found in the second book of Maccabees in the Old Testament found in a Catholic Bible.
4. What Is the most accurate way to describe Jews?
    a. A single race of genetically related people
    b. An ethnic group that share a common history, religion and cultural heritage
    c. A group of people that believe the same way religiously
5. True or False: With the exception of specific prayers said in the synagogue or after death, the Jewish perspective on prayer is the same as Christianity.

6. True or False: Jews and Muslims both reject any art depicting the Divine.
7. The four noble truths of Buddhism
    a. Meditation, reincarnation, enlightenment and suffering
    b. Suffering, the cause of suffering, the end of suffering and the path
    c. Ethical living, rebirth, truth telling, and decay of body
8. As death nears Buddhists believe:
    a. A person should be medicated as much as possible to allow a peaceful passage into the next life.
    b. Touch is important to the dying person.
    c. The level of pain relief needed must be balanced against the need for alertness in the dying Buddhist.
9. True or False: All Buddhist traditions require that a body be left undisturbed for eight hours after medical death.

APPENDIX B

Evaluation

Please do not put your name on this evaluation. If you have specific comments or questions that you would like a response from the investigator, please email them to Dana Cagle at dana.cagle@cst.edu.

Please circle how much you agree with each of the following statements:

1. I believe participating in this speaker series will help me in serving any patients I have or may have who identify as Roman Catholic.

Strongly agree Agree No opinion Disagree Strongly disagree

2. I believe participating in this speaker series will help me in serving my patients that I have or may have who identify as Jewish.

Strongly agree Agree No opinion Disagree Strongly disagree

3. I believe participating in this speaker series will help me in serving my patients that I have or may have who identify as Buddhist.

Strongly agree Agree No opinion Disagree Strongly disagree

4. I would like to hear more presentations from speakers of other faiths.

Strongly agree Agree No opinion Disagree Strongly disagree

If you would like to hear other speakers, please list below what faith/traditions/belief systems you would like to hear more about:

What did you like best about the speaker series? (Use back of evaluation if needed)

What did you like least about the speaker series? (Use back of evaluation if needed)

What suggestions do you have for improving future speaker series? (Use back of evaluation if needed)

Thank you so much for filling out this evaluation and your participation in this project!

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